BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **WILLIAM E. MORA, M.D.** Holder of License No. **13088** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-06-0173A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 6, 2007. William E. Mora, M.D., ("Respondent") appeared before the Board with legal counsel Peter F. Fisher for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 13088 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0173A after receiving a complaint regarding Respondent's care and treatment of a thirty-six year-old male patient ("WP") alleging improper prescribing and dispensing of opioids over a period of several years. WP first presented to Respondent in 1999 after injuring his thumb at work. None of Respondent's notes document a reason for WP's on-going pain, a rationale for the continuation or escalation of opioid dosages, or evaluation for WP's compliance or any side effects. Other than different dates, as many as twelve consecutive office visit notes were identical. Respondent routinely wrote prescriptions for short-acting opioids with three refills. Although Respondent documented WP did not use the refills, he continued to write the prescriptions with three refills on each prescription as frequently as every

three or four weeks. Pharmacy surveys confirm WP did indeed refill prescriptions for Number 180 Lortab at alternating pharmacies, sometimes in as few as seven days.

4. Respondent admitted his prescribing was a mistake. Respondent was in the process of trying to move WP into a pain management program and out of his practice. Respondent is a board-certified plastic surgeon who, for the past fourteen years, has focused on hands. WP presented to Respondent as a worker's compensation patient. The etiology of WP's pain was a crush injury suffered at work; there was no fracture, but ligamentous damage to the thumb. Respondent believed WP had two problems, one accepted and one unaccepted. The unaccepted problem was his complaint of pain from the CMC joint. The other problem was that WP's MCG joint was crushed with a hammer. After MRIs and scopes Respondent surgically fused the joint. Respondent started prescribing Lortab because of WP's continued pain with the CMC joint. WP then started coming to Respondent every month.

5. Respondent was treating WP's traumatic arthritis with pain medication. As Respondent looked back in his records he saw an escalation of prescriptions. Respondent was seeing up to 700 patients per month and WP would drop in occasionally asking for a prescription. Respondent was busy and not paying attention and when WP asked for drugs, Respondent would write the prescriptions. WP was getting more and more prescriptions and when it came to Respondent's attention he did not move fast enough to deal with the problem. Eventually Respondent referred WP to a family practice doctor to get him out of his practice. Respondent continued treating symptomatic discomfort and objective signs of symptomatic arthritis with pain medication. Respondent was passive-aggressive in the way he dealt with WP and was not paying attention. Respondent admitted he did not do the right thing.

6. From 2003 to 2005 there are twelve office visits documented for WP. At the time Respondent kept his notes in a variety of ways and believed the twelve office visit records are identical because he used a template in his computer and, because he had 700 patients and was

very busy, all he did was change the dates. The documented clinical findings are very sparse. Respondent admitted he did not help WP at all by giving him the narcotics. Respondent recalled WP's visits escalated and his narcotic use escalated, but Respondent did not pay attention. Respondent felt charity and empathy for WP, but did not understand there is a limit and he allowed WP to violate a boundary line that caused Respondent a conflict. Respondent was unaware patients would come to physicians seeking drugs or go doctor shopping to get drugs. Respondent has learned from this experience and has come to understand he has to be careful about maintaining his integrity, his character, and maintaining who he is. At the time he was treating WP he was not able to identify people who were manipulating him and he allowed WP to manipulate him. Respondent has learned that as a physician there are boundaries that must be maintained.

7. The standard of care requires a physician to monitor for, recognize, and follow-up on problems suggestive of aberrant drug-related disorders after prescribing opioids for chronic pain on a long-term basis.

8. Respondent deviated from the standard of care by failing to monitor for, recognize, and follow-up on WP's drug-seeking behavior.

9. WP's addiction was perpetuated and he could have suffered from Tylenol toxicity.

10. A physician is required to maintain adequate medical records. An adequate medical record means a legible record containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records do not meet this standard.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); A.R.S. § 32-1401(27)(j) ("[p]rescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes"); A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient of the public"); and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence or negligence resulting in harm to or the death of a patient.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for inappropriate prescribing and inadequate medical records and for prescribing for non-therapeutic purposes.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a

petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 10th day of August 2007.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 10th day of August, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 10th day of August, 2007, to:

Peter F. Fisher
Bradford Law Offices, P.L.L.C.
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Phoenix, Arizona 85016-6256

William E. Mora, M.D.
Address of Record

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